however, we would probably want to consider doing a comparative study of health outcomes of beneficiaries who have been screened by both physician and non-physician practitioners who have performed these examinations.

Such a study would mean that a number of physician and non-physician practitioners would have to collect and report data to us on their Medicare patients for a certain period of time, which could be burdensome for them. We may be interested in doing a study in this area in the future if we had any credible evidence of a serious problem in this area, but, at this time, we do not believe a study is necessary.

Result of Evaluation of Comments

We are adopting our proposal to allow certain non-physician practitioners to perform screening flexible sigmoidoscopies.

C. Services and Supplies Incident to a Physician's Professional Services: Conditions

Section 1861(s)(2)(A) of the Act authorizes coverage of services and supplies (including drugs and biologicals that are not usually self-administered by the patient) furnished incident to a physician's service. These drugs and biologicals are commonly furnished in physicians' offices without charge or included in the physicians' bills. This statutory ''incident to'' benefit differs from the ''incident to'' benefit in the hospital setting as set forth in section 1861(s)(2)(B) of the Act, which authorizes coverage of hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to a physician's service furnished to outpatients and partial hospitalization services furnished to outpatients incident to a physician's service. This provision only addresses coverage of ''incident to'' services under section 1861(s)(2)(A) of the Act. In addition, the statute provides Medicare coverage of services incident to practitioners other than physicians.

The Medicare Carriers Manual currently requires that the physician (or other practitioner) be either the employer of the auxiliary personnel or be an employee of the same entity that employs the auxiliary personnel. In the August 2, 2001 rule, we proposed to revise § 410.26 to codify our existing policy outlined in section 2050 of the manual. Specifically, we proposed to codify the definitions of auxiliary personnel, direct supervision, independent contractor, leased employment, non-institutional setting, practitioner, and services and supplies for purposes of services provided incident to a physician's service.

In addition, we proposed to allow auxiliary personnel to provide services incident to the services of physicians (or other practitioners) who supervise them, regardless of the employment relationship of the physician (or other practitioner) to the entity that employed the auxiliary personnel.

All commenters supported the proposal. Their specific comments are addressed below.

Comment: Commenters noted three errors in the proposed text of the regulation. First, in the definition of auxiliary personnel set forth in § 410.26(a)(1), after the phrase ''under the supervision of a physician,'' the term ''(or other practitioner)'' was omitted. Second, in the definition of services and supplies set forth in § 410.26(a)(7), the phrase ''(including drugs and biologicals that, as determined in accordance with regulations, cannot be self-administered)'' should be changed to ''(including drugs and biologicals which are not usually self-administered by the patient)'' in accordance with section 112 of the BIPA, which amended sections 1861(s)(2)(A) and (B) of the Act. Third, in the supervision requirement set forth in § 410.26(b)(5), the word ''direct'' was omitted.

Response: We agree with these comments, and we have corrected these errors.

Comment: One commenter requested that independent contractor physicians also be recognized as employees under the reassignment policy set forth in section 3060 of the Medicare Carrier Manual.

Response: As stated in the August 2, 2001 rule, this proposal only applies to the incident to policy. Furthermore, we are not defining or re-defining the term employment. Instead, we proposed to permit physicians (or other practitioners) to directly supervise auxiliary personnel regardless of the employment relationship of the physicians (or other practitioners) with the entity that hired the auxiliary personnel. In order to bill and receive payment from Medicare under this policy, all other applicable requirements must also be met. For example, the service must be medically reasonable and necessary, and appropriate reassignment must be executed.

Comment: One commenter suggested using in § 410.26(b) all of the terms defined in § 410.26(a) or deleting the terms not used in § 410.26(b).

Response: We found one term—leased employment—that was not used in § 410.26(b). However, we will not eliminate this term because it is used to define the term auxiliary personnel.

Comment: Several commenters requested that we clarify and distinguish between the physician (or other practitioner) ordering the incident to service and the physician (or other practitioner) supervising the auxiliary personnel who perform the incident to service. They stated that confusion exists as to whose Medicare Part B billing number should be used on the claim form.

Response: Inherent in the definition of an incident to service is the requirement that the incident to service be furnished incident to a professional service of a physician (or other practitioner). When a claim is submitted to Medicare under the billing number of a physician (or other practitioner) for an incident to service, the physician is stating that he or she either performed the service or directly supervised the auxiliary personnel performing the service. Accordingly, the Medicare billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel. We added language to the supervision requirement set forth in § 410.26(b)(5) to reflect this clarification.

Comment: One commenter pointed out that the claim form currently requires the physician (or other practitioner) to certify that he or she personally supervised the employee. Therefore, the commenter requested that we update the claim form to reflect the proposed regulations.

Response: We plan to update not only the claim form but also section 2050 of the Medicare Carriers Manual to reflect the new regulations.

Comment: A few commenters noted that the individual does not always receive an IRS–1099 form under an independent contractor arrangement. Instead, when a clinic, for example, contracts with an entity that has hired individuals to be furnished to the clinic, then the entity (and not the individual) receives the IRS–1099 form.

Response: We agree with these commenters. Therefore, we have added language to the definition of an independent contractor set forth in § 410.26(a)(3) to reflect this practice. However, we again emphasize that the applicable reassignment rules must also be met and that this incident to policy does not in any way alter the current requirements for valid reassignment.

Comment: One commenter encouraged us to specify in the regulations the acceptability of forms (other than the IRS W–2 form) that the Internal Revenue Service recognizes as

proof of employment, such as the Payroll Agent arrangement where IRS forms 2678 and 1997C are used instead.

Response: Under our proposal, the employment relationship is irrelevant to whether a physician (or other practitioner) can effectively furnish direct supervision of the auxiliary staff. Therefore, we decline to include language that may define or re-define the term employment.

Comment: One commenter suggested that we also include Ambulatory Surgical Centers (ASCs) and Community Mental Health Clinics (CMHCs) in the definition of a non-institutional setting because Medicare Part B payments for services provided in these settings are paid through the facility relative value units (RVUs) rather than the non-facility RVUs.

Response: The definition of a non-institutional setting is not derived from the definition of a facility used to determine the site of service and the application of the facility or non-facility RVUs. Because section 1861(s)(2)(B) of the Act authorizes payment for hospital incident to services, section 1861(s)(2)(A) of the Act cannot authorize payment for hospital incident to services. This provision is reiterated in § 411.15(m)(2). Similarly, § 411.15(p)(2)(ii) specifically excludes payment for incident to services in skilled nursing facilities (SNFs). Consequently, we defined non-institutional settings as all settings except hospitals and SNFs, and we do not plan to define ASCs and CMHCs as institutional settings.

Comment: Many commenters wanted us to restrict the definition of auxiliary personnel so that only certain individuals may perform a given incident to service. For example, they want us to mandate that only audiologists may perform cochlear implant rehabilitation services as incident to services. Likewise, they want us to permit only physical or occupational therapists to perform physical or occupational therapy as incident to services. In support, they noted that section 4541(b) of the BBA amended section 1862(a)(20) of the Act and required that physical or occupational therapy furnished as an incident to service meet the same requirements outlined in the physical or occupational therapy benefit set forth in sections 1861(g) and (p) of the Act.

Response: We have not further clarified who may serve as auxiliary personnel for a particular incident to service because the scope of practice of the auxiliary personnel and the supervising physician (or other practitioner) is determined by State law. We deliberately used the term any individual so that the physician (or other practitioner), under his or her discretion and license, may use the service of anyone ranging from another physician to a medical assistant. In addition, it is impossible to exhaustively list all incident to services and those specific auxiliary personnel who may perform each service.

Comment: Many commenters wanted us to re-emphasize that incident to services set forth in section 1861(s)(2)(A) of the Act do not include Medicare benefits separately and independently listed in the Act, such as diagnostic services set forth in section 1861(s)(3). Some even requested that we not permit these separately and independently listed services to be rendered as incident to services.

Response: We realize, as did the Congress with the enactment of section 4541(b) of the BBA, that many services—even those that are separately and independently listed—can be furnished as incident to services. However, this fact of medical practice is not inconsistent with our policy. We maintain that a separately and independently listed service can be furnished as an incident to service but is not required to be furnished as an incident to service. Furthermore, even if a separately and independently listed service is provided as an incident to service, the specific requirements of that separately and independently listed service must be met. For instance, a diagnostic test under section 1861(s)(3) may be furnished as an incident to service. Nevertheless, it must also meet the requirements of the diagnostic test benefit set forth in § 410.32. Namely, the test must be ordered by the treating practitioner, and it must be supervised by a physician. Thus, if a test requires a higher level of physician supervision than direct supervision, then that higher level of supervision must exist even if the test is furnished as an incident to service. Accordingly, we decline to prohibit a separately and independently listed service from being rendered as an incident to service. Instead, we reiterate that a separately and independently listed service need not meet the requirements of an incident to service.

Comment: Recognizing that this proposal affords flexibility in the way physicians (or other practitioners) are hired by an office or clinic, one commenter requested that non-physician practitioners be permitted to stand as *locum tenens* (taking the place of) for other non-physician practitioners as well.

Response: This proposed rule does not alter in any way the current *locum tenens* policy.

Result of Evaluation of Comments

We are finalizing our proposed revisions to § 410.26 with the corrections noted above.

D. Anesthesia Services

We generally use the 1988 American Society of Anesthesiologists' (ASA) Relative Value Guide as the basis for the uniform relative value guide. This guide is used in all carrier localities to determine payment for anesthesia services furnished by physicians under Medicare Part B. We proposed using the ASA base unit values from the 1999 guide beginning in CY 2002 for eight codes with ASA base unit values that were different from CMS's values (specifically, CPT codes 00810; 00902; 01150; 01214; 01432; 01440; 01770; and 01921). These are older codes and, while we accepted the ASA base unit value initially, the ASA has changed this base unit subsequently and no additional adjustment was made by us to the base unit. For CPT codes 00142 and 00147, we proposed maintaining the current base unit values although they differed from the ASA values because values for these two codes were established under the ''inherent reasonableness'' process in 1987.

Comment: The ASA identified additional CPT codes 00548, 00700, 00800, and 01916 with different base unit values in the most current ASA guide from our base unit values.

Response: We are accepting the ASA's comments subject to the following clarification. In all, 12 codes were presented where the ASA base unit differs from our base unit. Of these, code 01921, which appeared on the list in the August 2, 2001 proposed rule, will be deleted in 2002. Since this code has been deleted and will no longer be used, we will not assign base units to it and, as a result, only 11 codes will be considered.

These additional four codes were added to CPT before CY 2000. New and revised codes starting in CY 2000 and for subsequent years are evaluated on a code-specific basis under our usual process after we receive recommendations from the RUC. Thus, because we review the RUC recommendations and may make changes based on them, there could be differences between the ASA guide and our base unit values beginning in 2000. If the RUC or other commenters recommend and we agree to a base unit different from what ASA recommends, we will use that value and not the ASA